2001 Federal Annual Report
Children's Health Insurance Program

California

Gray Davis, Governor
STATE OF CALIFORNIA
January 2002

The California Managed Risk Medical Insurance Board
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January 14, 2002

Cheryl Austein-Casnoff
SCHIP Technical Director
Centers for Medicare and Medicaid Services
Mail Stop S2-01-16
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Baltimore, MD 21244-1850

Dear Ms. Austein-Casnoff:

Enclosed is the State Annual Report of the Children's Health Insurance Program. This report is required to be submitted to the Centers for Medicare and Medicaid Services in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Section 2108(a) of the Act provides that the State must assess the operation of the State Child Health Insurance Program (SCHIP) each fiscal year, and report to the Secretary by January 1 following the end of the fiscal year on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

The question and answer framework used in this report was developed by the National Academy of State Health Policy (NASHP) and was released to the States in August 2001.

If you have any questions or comments, please call me or Lorraine Brown, Deputy Director, at (916) 324-4695.

Respectfully,

Sandra Shewry
Executive Director

Enclosure

Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory:

CALIFORNIA

(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

SCHIP Program Name(s): HEALTHY FAMILIES/MEDI-CAL FOR CHILDREN

SCHIP Program Type:

____ Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
_X_ Combination of the above

Reporting Period: Federal Fiscal Year 2001 (10/1/2000-9/30/2001)

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(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002) Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

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SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility

NC. Children are eligible up to 250% fpl.

B. Enrollment process

California has developed a Web-based application process. This process, known as Health-e-App, is an intuitive application process and is currently being pilot tested in San Diego County. This application provides an immediate preliminary eligibility determination for Medicaid and/or SCHIP. Eligibility data and electronic documentation are transmitted to both County Welfare offices and the Administrative Vendor's Single Point of Entry system via the Internet. A preliminary business case analysis indicates significant processing time efficiencies and high user satisfaction.

C. Presumptive eligibility

NC. The HFP does not use presumptive eligibility.

D. Continuous eligibility

NC. Children enrolling in HFP or the Medi-Cal Program are guaranteed 12 months continuous eligibility.

E. Outreach/marketing campaigns

On January 29, 2001, the State launched new round (Phase II) of television, radio and print advertising. This new advertising provided greater information about program costs, ($4-$9 per child per month for Health Families Program, free for Medi-Cal), health dental and vision care services provided, choice of providers, and the availability of free application assistance and mail-in applications. The 888-747-1222 outreach number remained on the screen for the duration of the television ads. The Phase II changes were in response to focus group feedback asking for more information about the programs. Phase II resulted in a record number of calls to the toll-free line, requests for applications, and an increased number applications sent to the Healthy Families Program.

On July 1, 2001, the State awarded 30 new community-based contracts ($6,000,000) and expanded the outreach effort to include 25 school-based and school-linked contractors ($6,000,000). The expansion of outreach efforts to include schools is in recognition that schools offer a unique opportunity for enrollment activities. The state worked in collaboration with California Endowment, a California-based philanthropy, to provide funding for projects unable to be funded with state resources. The Endowment provided the State $1.5 million the State Fiscal years 2001-02 and 2002-03 for 14 additional community-based and school contracts.

The State has released new outreach posters that can be used by community-based organizations, providers and certified application assistants to highlight the same information as the television ads. These posters are available in the same 10 languages as the joint Healthy Families/Medi-Cal for Families applications. The State has also developed a similar, but distinct, poster for American Indians, featuring American Indian children. These posters indicate that there are no premiums or copayments for those who submit required documentation of American Indian Heritage.

Also, beginning in November 2000, following a training program, participating health plans became eligible to assist potential applicants with the completion of their applications. Participating health plans are required to submit a proposed plan for providing application assistance. Additionally, all participating health plan employees are required to complete a certified application assistance training class.

F. Eligibility determination process

NC.

G. Eligibility redetermination process

NC.

H. Benefit structure

NC.

I. Cost-sharing policies

NC.

J. Crowd-out policies

NC. The Healthy Families Program continued to exclude children from enrollment if they have had employer-sponsored health insurance in the last three months prior to their application, unless they meet one of five exceptions:

- The person or parent providing health coverage lost or changed jobs;
- The family moved into an area where employer-sponsored coverage is not available;
- The employer discontinued health benefits to all employees;
- COBRA coverage ended; or
- The child reached the maximum coverage of benefits allowed in current insurance in which the child is enrolled.

K. Delivery system

NC.

L. Coordination with other programs (especially private insurance and Medicaid)

NC. See appendix.

M. Screen and enroll process

NC.

N. Application

NC.

O. Other

NC.

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

The enrollment in the Healthy Families Program grew from 331,507 as of September 30, 2000 to 473,008 as of September 30, 2001. This represents a 43% increase in total enrollment during this period. The total number of ever enrolled increased to 664,661. On average, 18,296 children were newly enrolled each month during the FFY 2000.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

The Healthy Families Program and Medi-Cal for Children (MCC) screening process is conducted through a "Single Point of Entry" (SPE) process. All applications for the Healthy Families /Medi-Cal for Children Programs are mailed to this central location where they are initially screened for Medi-Cal income eligibility. During FFY 2001, 36% of applications received at the SPE were forwarded to the Medi-Cal program. Mail-in applications submitted via the SPE represent one avenue through which children enroll in Medi-Cal.

As of June 2001, 32,672 children were enrolled in Medicaid Expansion program and 2,153 in the Medi-Cal to HFP One Month Bridge. Over 2.7 million children are enrolled in California's Medicaid Program.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

Between 1999 and 2000, the number of uninsured children eligible for either HFP or Medi-Cal fell from approximately 1.5 million to approximately 1.3 million.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

____ No, skip to 1.3

__X__ Yes, what is the new baseline?

667,472

What are the data source(s) and methodology used to make this estimate?

The baseline is calculated by using the HFP enrollment data and the 2000 Current Population Survey (CPS) as analyzed by the UCLA Center for Health Policy Research. Technical notes can be found in *The State of Health Insurance in California: Recent Trends, Future Prospects* and at the UCLA Centers website: www.healthpolicy.ucla.edu.

What was the justification for adopting a different methodology?

The methodology used for estimating the baseline did not change. The change in the baseline estimate is the result of updated information regarding the uninsured that was included in the 2000 CPS and change in the HFP enrollment.

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

UCLA Center recommends the estimate be viewed as an approximation for two reasons:

- The CPS sample sizes of uninsured children in these subgroups are small, and consequently, result in unstable and imprecise estimates; and
- The CPS does not ask respondents whether they are documented or undocumented immigrants. The UCLA Center, therefore, modeled documentation status in order to exclude from the estimates those children who would be ineligible for any public coverage other than emergency Medi-Cal services.

The CPS is widely believed to undercount Medi-Cal enrollment and therefore overstate the number of uninsured children. The Urban Institute's TRIM2 model attempts to adjust for the Medi-Cal undercount by aligning Medi-Cal enrollment on the CPS to Center for Medicare and medicaid Services (CMS) administration data. The adjustment imputes enrollment having been to individuals meeting Medi-Cal eligibility criteria to match HCFA's estimates of individuals ever on the Medi-Cal program at any time during the year. This is consistent with the way the CPS poses questions about insurance coverage. It will overstate the number of Medi-Cal and understate the uninsured at a point in time. The number of children who are eligible for Medi-Cal as well as the number of uninsured at any point in time probably lies between the CPS and the Urban Institute's estimates.

As discussed in the above section, the CPS is widely believed to undercount Medi-Cal enrollment and therefore overstate the number of uninsured children. The UCLA study has cautioned that the total estimate be viewed as a range and not an absolute value.

With this in mind, it is appropriate to display the HFP progress in reducing the number of uninsured children by reviewing changes from FFY 2000 in both the estimates and the actual subscriber growth.

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

If the baseline had not changed, California would have achieved a 144% penetration of the March 2000 Evaluation original baseline estimate of **328,000.** It is important to keep in mind that a significant increase in the baseline between the March 2000 evaluation and FFY 2001 was due expansion in eligibility to 250% FPL.

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2: List the performance goals for each strategic objective.
Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: ***If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3.***

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
1.3.1 Increase Awareness	1.3.1.1 Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.	Data Sources: CA Department of Health Services Methodology: Analyze changes in number of eligible children in Medicaid in FFY 1999 and FFY 2000. Progress Summary: See narrative on page 13.
	1.3.1.2 Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.	Data Sources: CA Department of Health Services and "State of Health Insurance in California" Brown UCLA 2001 Methodology: Analyze changes in number of eligible uninsured children during FFY 2001. Progress Summary: See narrative on page 14.
	1.3.1.3. Reduce the percentage of children using the emergency room as their usual source of primary care.	Data Sources: See progress summary. Methodology: See progress summary. Progress Summary: MRMIB is currently investigating alternative data sources for monitoring the changes in this measure. It is also accessing the utility of this measure as a predictor of the contribution the HFP has in lowering rates.

OBJECTIVES RELATED TO SCHIP ENROLLMENT		
1.3.2. Provide an application and enrollment process which is easy to understand and use.	1.3.2.1. Ensure Medi-Cal and HFP enrollment contractor provide written and telephone services spoken by target population.	Data Sources: Enrollment Contractors/Enrolled Entities Methodology: Review and survey of current materials. Progress Summary: See narrative on page 14.
1.3.3. Ensure that financial barriers do not keep families from enrolling their children.	1.3.3.1. Limit program costs to two percent of annual household income.	Data Sources: Internal Enrollment Data, program design data, survey data Methodology: Review and analysis. Progress Summary: See narrative on page 15.
1.3.4. Ensure the Participation of Community Based Organizations in Outreach/Education Activities.	1.3.4.1. Ensure that a variety of entities experienced in working with target populations are eligible for an application assistance fee.	Data Sources: MRMIB/DHS financial records Methodology: Summary of expenses for application assistance from 10/1/00 to 9/31/01. Progress Summary: See narrative on page 16.
	1.3.4.2. Ensure that a variety of entities experienced in working with target populations and have subcontracts have input to the development of culturally and linguistically appropriate outreach and enrollment materials.	Data Sources: Outreach and Education Contracts/Enrolled Entity Survey Methodology: Review contract listing. Progress Summary: See narrative on page 16.

OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
1.3.5. Provide a choice of health plans.	1.3.5.1. Provide each family with two or more health plan choices for their children.	Data Sources: Enrollment data from Healthy Families Program Administrative Vendor - Electronic Data Systems (EDS) Methodology: Data extract and reports from vendor database of percent of enrollment by county and number of health plans per county. Progress summary: See narrative on page 16.
1.3.6. Encourage the inclusion of traditional and safety net providers.	1.3.6.1. Increase the number of children enrolled who have access to a provider within their zip code.	Data Sources: Data from administrative vendor/provider locations from GeoAccess Methodology: Review change in penetration pre and post HFP implementation. Progress Summary: Approximately **6.8%** of total subscribers live in a zip code that has no provider.
	1.3.6.2. Increase the number of children enrolled who have access to a traditional and safety net provider as defined by MRMIB.	Data Sources: Health Plan Traditional & Safety Net Provider Report CPP Designations Methodology: Reports submitted by Healthy Families Participating health plans on the number of children who have a Traditional and Safety Net provider as their PCP. Progress Summary: See narrative on page 16.

OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED) cont'd		
1.3.7. Ensure that all children with significant health needs receive access to appropriate services.	1.3.7.1. Maintain or improve the percentage of children with services.	Data Sources: HFP enrollment, CCS, County mental health data Methodology: Review and analysis of mechanisms in place to serve children with significant health problems. Track complaints from children with special needs. Progress Summary: See narrative on page 17.
	1.3.7.2. Ensure no break in coverage as they access specialized services.	Data Sources: HFP enrollment, CCS, County mental health data Methodology: Review and analysis of mechanisms in place to serve children with significant health problems. Track complaints from children with special needs. Progress Summary: See narrative on page 17.
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
1.3.8. Ensure health services purchases are accessible to enrolled children.	1.3.8.1. Achieve year to year improvements in the number of children that have had a visit to a primary care physician during the year.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Please see attached report titled, *Quality Measurement Report – 2000*.
	1.3.8.2 Achieve year to year improvements in the number of children who have had a child exam at appropriate interval.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Please see attached report titled, *Quality Measurement Report – 2000*.

	1.3.8.3. Achieve year to year improvements in the number of children who have received immunizations by age 2 and age 13.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Please see attached report titled, *Quality Measurement Report – 2000*.
OTHER OBJECTIVES		
1.3.9. Strengthen and encourage employer - sponsored coverage to maximum extent possible.	Maintain the proportion of children under 200% FPL who are covered under an employer based plan. Adjust for increased costs.	Data Sources: Application Data Methodology: Summarize responses from HFP applications. Numerator: Number of applicants that had coverage through an employer within the prior 90 day period Denominator: Total applicants Progress Summary: In order to prevent crowd-out, applicants to the Healthy Families Program must answer questions about their previous health coverage. Data collected from the implementation of the Healthy Families Program indicates that 4.88% of successful applicants had coverage through an employer within the prior 90-day period. Of the applicants who indicated they had coverage within the prior 90 days, 61% indicated loss of employment, 13% had an employer who discontinued benefits to all employees, 7% cited end of COBRA coverage and the remainder indicated other reasons. These numbers indicate that crowd-out has not affected the HFP to any significant degree. In addition, 4.84% of unsuccessful applicants had coverage through an employer within 90 days prior to enrollment and were denied enrollment due to the employer-based coverage. (These unsuccessful applicants represent 1.39% of all applicants.)

Narrative 1.3.1.1 ***Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.***

There has been an increase in the total number of children in Medi-Cal between June 2000 and June 2001. Most notable is a 56.78 % increase in the number of children in the Medicaid Expansion program. There was a decrease in the number of children in the One-Month Bridge program but there are several reasons why this has occurred. Effective January 1, 2001, Medi-Cal no longer requires a Quarterly Status Report (QSR). Without the QSR, eligibility redeterminations are done annually and changes do not occur as frequently.

Children Enrolled in Medi-Cal and One Month Bridge

	June 2000	June 2001	Change	Percent Change
Total Medicaid	2,594,336	2,744,428	150,092	5.79%
Regular Medicaid	2,573,497	2,711,756	138,259	5.37%
Medicaid Expansion	20,839	32,672	11,833	56.78%
One Month Bridge	3,284	2,153	(1,131)	-34.44%

From Healthy Families Medicaid Expansion, Regular Medicaid, and One Month Bridge Eligibles Later Updates to the Data for the CHIP Quarterly Statistical Reporting on the CMS-64 21E, HCFA-64EC and CMS-21E 10/30/2001. Prepared by Fiscal Forecasting and Data Management Branch.

Medi-Cal 12-month Continuous Eligibility for Children (CEC) was implemented January 1, 2001 and has had a major impact on eligibility for children.

In comparison to the decrease in families eligible for CalWORKS cash grants, the Medi-Cal program has had an increase in the overall number of children enrolled. This maintenance of Medi-Cal enrollment of children can be attributed to the outreach efforts and the State's implementation of changes in the Medi-Cal program. These efforts and changes have had a combined effect of making it easier for families and children to apply for and stay on Medi-Cal.

The Department of Health Services has allocated $17.9 million in fiscal years 1999-00 and 2000-01 to counties to conduct Section 1931(b) outreach activities. This includes outreach to families who will be losing their coverage within 30 days to complete the redetermination process and to inform working families about the availability of Medi-Cal coverage, which is not linked with TANF (CalWORKS). On March 1, 2000, the income eligibility for the Section 1931(b) program was increased to 100 percent of poverty and the definition of deprivation was changed so that working parents with earned incomes at or below 100 percent of poverty would be eligible. The Department of Health Services sent notices to Medi-Cal eligible families notifying them of this change in program eligibility in April 2000 and again in May, 2001.

For the Healthy Families/Medi-Cal for Children program, the State has adopted a simplified, joint mail-in application. Effective July 1, 2000, the State eliminated the face-to-face interview for Medi-Cal. Effective October 1, 2000, the State adopted the foster care federal option that continues Medi-Cal coverage from age 18 to 21 for youth who transition out of foster care. Effective January 1, 2001, the State eliminated the quarterly status report and adopted 12-month continuous eligibility for children. Effective July 1, 2001, there were changes in Medi-Cal eligibility criteria and procedures with regard to when eligibility is terminated and when circumstances change that affect eligibility.

<u>Narrative 1.3.1.2:</u> Reduce the percentage of uninsured children in target income families that have family income above no cost Medi-Cal

<u>Denominator</u>- HFP eligible baseline (see Question 1.2 D, pages 4 through 6, for a detailed description)

D = New estimated number of uninsured children in target income families
= 667,472

<u>Numerator-</u> Actual number of uninsured children insured under HFP during the reporting period.

N = Actual number of uninsured children insured under HFP during reporting period.
= 473,008

<u>Progress toward goal</u>-Estimated reduction in the percentage of uninsured children in target income families that have family income above no cost Medi-Cal:

P = N/D
= <u>71%</u>

<u>Narrative 1.3.2.1:</u> Ensure Medi-Cal and HFP enrollment contractor provide written and telephone services spoken by target population.

Applicants can receive enrollment instructions, applications, and handbooks in ten languages. These languages include English, Spanish, Vietnamese, Khmer, Armenian, Chinese, Korean, Russian, and Farsi. In addition, Healthy Families has all correspondence, billing invoices and other program notification materials translated into five languages. These languages include; English, Spanish, Chinese, Korean, and Vietnamese.

In July 2001 Healthy Families implemented a new call center for enrolled members. This call center has a toll free number, (866) 848-9166. This dedicated line is available for members to inquire about their account or to provide information to keep their account current (e.g., address change, etc). All call centers expanded their hours to Monday - Friday between 8 a.m. and 8 p.m. and on Saturday 8 a.m. and 5 p.m.

A team of operators proficient in the eleven designated languages in which campaign materials are published staff the line. The following table describes the frequency of calls by language:

Language	HFP/MCC Single Point of Entry		HFP/MCC Outreach	
	Program to Date	**% of Total**	**Program to Date**	**% of Total**
English	1,258,171	54.42%	731,340	69.55%
Spanish	879,670	38.05%	275,423	26.19%
Cantonese	44,827	1.94%	10,939	1.04%
Korean	14,980	.65%	5,231	.50%
Vietnamese	12,611	.55%	13,519	1.29%
Armenian	22,711	.12%	743	.07%
Russian	3,082	.13%	1,621	.15%
Cambodian	1,076	.05%	707	.07%
Hmong	569	.02%	1103	.10%
Farsi	2,351	.10%	573	.05%
Lao	123	.01%	NA	NA

***Narrative 1.3.3.1:* Limit program costs to two percent of annual household income.**

California continues to limit Healthy Families Program costs to below two percent of annual household income. The following table represents the aggregate distribution of income and premiums for enrollees during the reporting period. The maximum weighted average program costs based on the mix of actual program enrollees as a percent of income was 1.4%.

This analysis assumes an average family size of four, 36% of subscribers receiving the $3/month discount for enrolling with a Community Provider Plan (please see narrative for 1.3.6.1 on the following page), and expending the maximum health co-payment of $250. The $250 co-payment equals 50 visits or prescriptions per year at $5 per visit. During the 200/2001 benefit year, 0.1% of HFP members spent the maximum in copayments.

Aggregate Income and Premium Statistics

Countable Income Level. Federal Poverty Level (FPL)	Percent mix of Subscribers	Average Annual Premium (assuming 39% take $3 discount)	Maximum Allowable Health Co-payments	Maximum Total Program Cost	Average Annual Income	Maximum Program Cost as a Percent of Income
Under 150%	41%	$140	$250	$390	$24,464	1.6%
Over 150%	59%	$188	$250	$438	$35,310	1.2%

***Narrative 1.3.4:* Ensure the Participation of Community Based Organizations in Outreach and Education Activities.**

Community-based organizations are an integral part of the Healthy Families Program and Medi-Cal Program Outreach strategy. As of September 2001, 61% of applications received through the *Single Point of Entry* process were assisted by organizations that participated in the application assistance fee program. $5,000,000 in fees were paid to these community groups in State FY 00/01. In addition, a total of $6 million was allocated to HF/MCC CBO outreach contracts in the State FY 00/01.

***Narrative 1.3.5.1*: Provide each family with two or more health plan choices for their children.**

The Healthy Families Program offers a broad range of health plans for program subscribers. A total of 26 health plans participated in the program during the reporting period. Over 99% of subscribers had a choice of at least two health plans from which to select.

***Narrative1.3.6.2:* Increase the number of children enrolled who have access to a traditional and safety net provider as defined by MRMIB.**

As an incentive to include traditional and safety net providers in their network, health plans with the highest percentage of traditional and safety net providers in their network are designated as a Community Provider Plan (CPP). Plans with the Community Provider Plan designation are offered at a $3 discount per child per monthly premium discount. Traditional and safety net providers are available in all areas of the state, and all HFP subscribers have access to them.

Sixteen of 26 participating health plans are designated as a Community Provider Plan (CPP) in at least one county. Of all HFP subscribers, 36% are enrolled in a CPP and receive a $3 discount.

***Narrative 1.3.7*: Ensure that all children with significant health needs receive access to appropriate services:**

Children enrolled in the HFP are referred to the California Children's Services (CCS) Program or county mental health departments, depending upon their special health care needs. These referrals may originate with the health plans participating in the HFP, or from other sources such as schools or families. Reports submitted by participating plans indicated that 4,994 children were referred to the CCS program and that 1,098 children were referred to county mental health during the 2000/01 State fiscal year. To facilitate the tracking of these children, the State has implemented two administrative systems that became fully operational on December 31, 2000.

The State monitors access to services for children with special health care needs by holding routine meetings with health, dental and vision plans and the CCS and county mental health programs and through follow-up on complaints received from subscribers. The routine meetings with plans and the programs allow the State and plans to discuss any arising or foreseeable barriers to access, and way to eliminate these barriers. Newsletters were developed for county mental health programs to reinforce referral protocols for health plan/county mental health referrals and to provide county mental health departments with updates on the HFP. The California Institute of Mental Health in collaboration with the State developed these newsletters. During the reporting period, brochures were distributed to families to better educate them about the CCS and county mental health programs.

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

MRMIB is conducting the Healthy Families Children's Health Status Assessment Survey over a three-year period that started February 2001. The survey tracks change in the physical, emotional, and social health of HFP subscribers, and will allow MRMIB to quantify the benefits of enrollment in the HFP.

In addition, MRMIB has been working with RAND to conduct a dental satisfaction survey based on CAHPS®. It is anticipated that the survey results will be available in spring 2002.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

- Quality Measurement Report 2000
- 2001 Consumer Assessment of Health Plan Survey (CAHPS®)
- 2001 Evaluation of HFP/MCC Outreach
- 2001 Open Enrollment Report

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

California did not offer family coverage. In December 2000, California submitted an SCHIP 1115 Demonstration Waiver Request seeking approval to use funds to cover uninsured parents of children enrolled in the HFP and/or Medi-Cal. As of December 2001, the waiver remains under review by CMS.

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

NA Number of adults
NA Number of children

C. How do you monitor cost-effectiveness of family coverage?

NA

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

NA Number of adults
NA Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

Crowd-out is defined as the substitution of employer-based coverage for publicly funded (e.g., Medicaid and SCHIP) coverage. It is also defined as employers dropping health insurance coverage because public alternatives are available. Children who have had employer-sponsored coverage three months prior to the date of application are not eligible for the HFP.

B. How do you monitor and measure whether crowd-out is occurring?

Crowd-out is monitored through the eligibility determination process and the collection of data. Applicants must answer questions about each child's previous health coverage. Children who received employer-based health coverage 90 days prior to application are not eligible for the HFP, unless they qualify for specific exemptions.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Data collected from the implementation of the HFP indicates that 4.88 percent of successful applicants had coverage through an employer within the prior 90-day period. The following reasons were provided as to why the children did not have coverage at the time of application or would no longer be covered on the effective date of enrollment.

- 2.97 percent stated their child(ren) would be uninsured due to loss of employment.
- .39 percent had an address change to where no coverage was available through the employer's plan.
- .65 percent had an employer who discontinued benefits to all employees.
- .34 percent cited the end of COBRA coverage.
- .54 percent listed other.

In addition, 4.84% of unsuccessful applicants had coverage through an employer within 90 days prior to enrollment and were denied enrollment due to the employer-based coverage. (These unsuccessful applicants represent 1.39% of all applicants.)

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

The crowd-out policies that were implemented through the eligibility determination process appear to have been successful. Applicants are required to report whether their children have had previous health insurance coverage. The applicants are also required to report the reasons why they do not have coverage at the time of application. The policies have worked to discourage substituting public coverage for private coverage. Based on the analysis of the current policies of crowd-out, these appear to have been effective.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

The education and outreach campaign is a combination of advertising, collateral and public relations, community and school-based outreach, and certified application assistance. All of these efforts reinforce each other in targeting all eligible children for the Healthy Families and Medi-Cal Programs. The advertising generates calls to the programs' toll-free number, and name recognition when community-based organizations (CBO) and schools do outreach, which generates requests for application and assistance. There is a correlation between advertising and the calls to the toll free line, with increases in the number of telephone calls when the ads are on air and a decrease in calls when off-air. Also, there is an increase in the number of applications returned to HFP and an increase in enrollment.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

See above response. Many of the community based and school contractors serve designated target populations and develop appropriate strategies for those populations, recognizing and responding to unique barrier to enrollment.

C. Which methods best reached which populations? How have you measured effectiveness?

The advertising campaign includes English, Spanish, Russian/Armenian, Asian-language advertising, and American Indian posters. The community-based outreach efforts are developed by each of the 69 contractors based upon the needs of the communities they serve.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

In May 2001, the MRMIB conducted an extensive analysis of reasons why children disenroll from HFP. Disenrollments fall into *two categories*; "possibly avoidable" and "unavoidable" reasons. The unavoidable reasons include attainment of age 19, moving out of state, and income too high or too low. The most significant avoidable disenrollment reasons include non-payment of premiums, and not returning or completing the Annual Eligibility Review forms. California uses several strategies to attempt to reduce these disenrollment reasons and to determine why children are disenrolled for these reasons.

These efforts include Courtesy Calls to families 10 days prior to the disenrollment for non-payment of premiums. During these calls pertinent case information is verified (e.g., mailing address) and data is collected to obtain the true reason the applicant is not making a payment (e.g., obtained other private or employer insurance). Information about making cash payment at a Rite Aid store prior to the disenrollment is also provided. The billing statements are also translated into five languages in an effort to ensure applicants understanding the payment requirements of the HFP.

For the AER forms, a courtesy call is conducted 30 days prior to the disenrollment date. Again, pertinent case information is obtained, assistance in completing the application is provided (if needed), families language spoken and read is verified, and information to fax an AER form to avoid a possible break in service is provided.

Effective January 1, 2001, the requirement for a Medi-Cal beneficiary to complete, return and submit income verifications on a quarterly basis via a Quarterly Status Report (QSR) for Medi-Cal, was eliminated. California estimates that with the elimination of the QSR, 250,000 children have benefited by continued Medi-Cal eligibility.

Effective July 1, 2001, counties implemented the *ex parte* process. This provides a seamless transition from CalWORKs to Medi-Cal-only benefits by using existing information available in other programs and does not require a new application. Previously, every person or family discontinued from cash benefits was required to complete a packet of forms and submit verifications. This resulted in many persons/families losing Medi-Cal coverage for failure to return forms/information. *Ex parte* has streamlined the Medi-Cal program to avoid discontinuing Medi-Cal for those who are eligible.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

____ Follow-up by caseworkers/outreach workers
__X__ Renewal reminder notices to all families
____ Targeted mailing to selected populations, specify population
____ Information campaigns
____ Simplification of re-enrollment process, please describe
__X__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe:

Two telephone calls are made to families who are disenrolled from the program to determine the reason for their disenrollment. If HFP is unable to reach the applicant by telephone, a postcard is sent to the applicant to request a reason for disenrollment. This information is reported each month on the disenrollment telephone survey report.

__X__ Other, please explain

HFP subscribers are disenrolled for non-payment of premiums 60 days after the last premium was received. Prior to being disenrolled, subscribers receive a billing statement 30 days after premiums are not received notifying them that they will be disenrolled in 30 days. Fifteen days before they are disenrolled another warning letter is mailed. Starting in May 2001, subscribers also are called ten days prior to disenrollment to confirm their receipt of notifications and to determine the reason for their non-payment.

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

Medi-Cal program policies contain multiple safeguards to avoid unnecessary discontinuance. Because of continuous eligibility, children only disenroll for failure to comply with the annual process, or when changes in their circumstances make them ineligible at annual redetermination. Families who fail to provide the necessary documentation during annual redetermination are given several chances to remain in the program. A beneficiary is first contacted by telephone (if available) and then sent a notice requesting the information to be returned to the county. The families are then given 20 days to provide the information requested. Services are not interrupted during this time. If the family does not return the forms, counties are required to exhaust all avenues of eligibility before discontinuing benefits. Once all avenues are exhausted and the case is discontinued, Medi-Cal will reinstate their benefits if documents are returned within 30 days of the discontinuance. Additionally, families who lose linkage to the Medi-Cal program due to changes in their circumstances are asked to provide any additional information that may make them eligible under a different Medi-Cal category.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

By following up with the applicant to ensure the Annual Eligibility Review materials have been received and returned, HFP ensures timely re-determination and continued eligibility.

The Annual Eligibility Review (AER) packet is sent to applicants 60 days prior to the children's anniversary date. The packet requests notification of changes in family status, size and updated income documentation within 30 days. The packet provides customized information for each family and notifies them of the response due date.

If the applicant does not respond after 30 days, a reminder postcard is mailed. This postcard notifies the applicant that they may lose coverage if they do not respond. A telephone number is provided for applicants to call.

After the postcard is mailed, the enrollment vendor attempts to call the HFP applicant by phone three times, at different times during the day, during the second thirty-day period.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

As of October 5, 2001, to date, 4% of children were disenrolled at the time of their Annual Eligibility Review due to their current enrollment in No-Cost Medi-Cal, and 0.9% for obtaining employer sponsored coverage.

Between April 2001 and August 2001 MRMIB attempted to call subscribers who were to be disenrolled due to non-payment of premiums. Disenrollment for non-payment of premiums accounts for 36% of all disenrollments. During these five months 24% were contacted and it was found that 12% had obtained other insurance (8% employer-based, 3% Medi-Cal, 1% private).

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and redetermination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

The HFP/MCC programs use a joint application. All applications are received at a Single Point of Entry (SPE) are screened for no-cost Medi-Cal eligibility. The application is then forwarded to either HFP for SCHIP determination or the CWD for Medi-Cal eligibility determination. SPE also documents the date applications are received and the date they are forwarded to County Welfare Departments (CWD). The income and deduction verification is the same for children applying for Medi-Cal and/or HFP. If the joint application is received by a county, the county will use it as a Medi-Cal application.

The Administrative Vendor completes the Annual Eligibility Review (AER) for SCHIP. A preprinted customized AER packet is mailed to the HFP applicant 60 days prior to the children's anniversary date to verify all information and new income documentation is requested.

In Medicaid the redetermination forms are mailed out by the CWD to the applicant 45 days prior to the child's anniversary date.

The deduction and income documentation are the same for children in either program.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

In SCHIP, if an applicant is determined to be ineligible due to income (too low) at AER and the applicant has requested Medi-Cal screening, the AER application is forwarded to the CWD in which the child resides for a Medicaid determination.

In the Medicaid program, when a redetermination done by CWD determines that the child has a share of cost due to change in family circumstances, the family is notified of their share of cost and termination date for no cost Medicaid. An additional month of no cost Medicaid (bridging program) is granted to the child so that the applicant can apply for and enroll the child in the HFP.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

There is a significant overlap in the managed care networks for HFP and for Medi-Cal. Of the 26 health plans offered by the HFP, 23 participate in the Medi-Cal program. Approximately 74% of HFP subscribers are enrolled in plans that participate in both programs.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

To date, disenrollment for non-payment of premiums accounts for 36% of all disenrollments. MRMIB attempts to survey all subscribers disenrolled due to non-payment of premiums. Only 33% of disenrolled subscribers responded to the survey (July 2000 – August 2001). 11.9% of the 33% that responded stated they could not afford premiums.

Between April 2001 and August 2001 MRMIB also attempted to call subscribers who were to be disenrolled due to non-payment of premiums. During these five months 24% were contacted and it was found that only 3% indicated they could not afford premiums.

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

There are many services that are provided in the Healthy Families Program that do not require copayments. The program was designed with this feature to eliminate a potential barrier to services. Preventative health and dental services and all inpatient services are provided without copayment. Copayments are not required for services provided to children through the California Children's Services Program and the county mental health departments to the children who are seriously emotionally disturbed (SED).

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

MRMIB obtains information on quality of care through health and dental plan reporting requirements and subscriber surveys. The sources of information used to obtain data on the quality of care delivered through health, dental and vision plans includes the following:

Fact Sheets
Fact Sheets are submitted by each health, dental and vision plan interested in participating in the Healthy Families Program. The questions that are included in the Fact Sheet request information about the organization of the plans and the provision of health, dental and vision care services. Some of the specific areas that are addressed include access to providers, access to plan services, including customer service, standing with regulatory entity or accrediting body, and process for handling member grievances. Fact Sheets are submitted by the plans annually.

Annual Quality of Care Reports
Each year, health and dental plans are required to submit quality of care reports based on HEDIS® and a 120-day health (and dental) assessment measure. The HEDIS® reports for health plans focus on the number of children who have been immunized and on the number of children receiving well child visits. Because preventive care is vital to young children and is the cornerstone of care provided through the HFP, the annual quality of care reports provide an indication of how well a particular plan is providing health or dental care to members. A copy of the report is attached and contains current data for the 1999 and 2000 calendar years.

California Children's Services (CCS) and Mental Health Referral Reports
The CCS and Mental Health Referral Reports were implemented in FFY 2000 to monitor the access that eligible children have to CCS and county mental health services. Plans are required to report on a quarterly basis the number of children referred to these services. The numbers reported by plans will be compared with the estimates of children expected to require CCS and county mental health services to determine whether there is adequate access to these services.

Cultural and Linguistics Services and Group Needs Assessment Reports
These reports allow staff to monitor how special needs of HFP subscribers related to language access, and culturally appropriate services are being met. The Cultural and Linguistic Services Report outlines how plans will provide culturally and linguistically appropriate services to subscribers. Specific information obtained for the report included:

- How plans assign subscribers to culturally and linguistically appropriate providers
- How plans provide interpreter services to subscribers
- How plans provide culturally and linguistically appropriate marketing materials
- A list of written materials plans make available in languages other than English

The Group Needs Assessment Report identifies the unique perspectives of subscriber based on their cultural beliefs. Participating plans are required to conduct an assessment of their subscribers to determine:

- Health-related behaviors and practices
- Risk for disease, health problems and conditions
- Knowledge, attitudes, beliefs and practices related to access and use of preventive care
- Knowledge, attitudes, beliefs and practices related to health risk
- Perceived health, health care and health education needs and expectations
- Cultural beliefs and practices to alternative medicine

The assessment must also include an evaluation of community resources for providing health education and cultural and linguistic services and the adequacy of the network. Based on the results of the assessment, each plan is required to develop a program to address the needs identified in the group needs assessment. Participating plans submitted their first group needs assessment reports in June 2001.

Member Surveys
MRMIB uses two member surveys to monitor quality and service. During open enrollment, all subscribers are given a plan disenrollment survey. The survey requests information on why members switch plans during open enrollment. Questions on the survey address plan quality, cost, adequacy of the provider network, and access to primary care providers. The comparison of disenrollment trends and results from the disenrollment surveys provide another tool for monitoring plan performance. For further information please see attached report.

The second survey, a consumer satisfaction survey, was conducted in the Fall of 2000. The survey was conducted in five languages (English, Spanish, Chinese, Korean, Vietnamese) and was based on the Consumer Assessment of Health Plans Survey (CAHPS® 2.0). MRMIB is currently working with RAND to analyze responses to among disparities and differences between language groupings. Responses from the survey will provide information on access to care (including specialty referrals), quality of provider communication with subscribers, and ratings of providers, health plans and overall health care. For further information please see attached report.

Subscriber Complaints
MRMIB receives direct inquiries and complaints from HFP applicants. Ninety percent of the inquiries are received via correspondence and ten percent through phone calls. All HFP inquires and complaints are entered into a data file that is categorized by the subscriber's plan, place of residence, the families' primary languages and type of request. This data enables staff to track complaints by plan and to: 1) monitor access to medical care by plan, 2) evaluate the quality of health care being rendered by plan, 3) evaluate the effectiveness of plans in processing complaints, and 4) monitor the plan's ability to meet the linguistic needs of subscribers.

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

See Question A which begins on the previous page.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

A system is in place to review quality of care, as measured through the currently available quality measures, by certain demographic variables. These variables include age, language, ethnicity, and location. This system will provide the ability to identify quality-related issues (e.g., disparities in immunization rates, consumer satisfaction, etc.) that may arise with any demographic group represented in the program. HEDIS® and CAHPS® data will be analyzed for year-to-year trend analysis.

Starting in January 2002, working with RAND, MRMIB will conduct the first Dental CAHPS® project to measure subscriber experiences with dental care. Results will be available in the Spring of 2002.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility

The revised joint mail-in application and the Single Point of Entry (implemented April 1999) continued to improve the eligibility determination process. The application was revised to included an application tracking number (bar code) which improves tracking and payments to Certified Application Assistants. The Single Point of Entry has significantly improved the screening for no-cost Medi-Cal in a consistent and uniform manner and has provided an efficient system to forward applications to county welfare departments.

The continued posting of enrollment, disenrollment, and Single Point of Entry information on the MRMIB website has been a valuable tool for community-based organizations, local governments and other interested parties who are interested in evaluating the number of children enrolled in their county.

B. Outreach

The Medi-Cal for Children and Healthy Families Program (MCC/HFP) Outreach and Education Campaign has been successful in accessing hard to reach populations, minorities, and rural areas. Indicators of the campaign's success in reaching targeted populations include:

- Continued enrollment growth in the HFP
- 385,743 phone calls to the campaign's toll-free line for information and referral service.
- 215,608 applications and handbooks mailed out.
- 36,493 requests for applications as a result of school outreach efforts.
- Funds to continue reimbursing Certified Application Assistants for enrolling children in MCC/HFP.
- Continue $6 million funding to local CBOs through contracts to conduct local outreach

Increase in efforts to heighten public awareness through a variety of activities including celebrity endorsers, sponsorship promotions and school outreach among Latino, African-Americans, and other communities.

C. Enrollment

D. Retention/disenrollment

This area of program administration is the focus on ongoing management review. In collaboration with the National Academy for State Health Policy, California is working with other states to identify best practices and barriers to retention. Activities that appear successful in addressing retention and disenrollment include:

- Courtesy calls placed 30 days prior to the anniversary date to confirm receipt of the Annual Eligibility Review package and to encourage timely submissions.
- Reminder post card mailed 30 days prior to the anniversary date to remind applicants to send in their Annual Eligibility Review Package.
- Telephone surveys of families who are disenrolled for non-payment of premium to determine the reason they did not pay.
- Ongoing collaboration with Community Based Organizations, CAAs and contracted plan partners to develop retention strategies.
- Courtesy calls to subscribers 10 days prior to disenrollment.
- Billing statements in five languages (English, Spanish, Vietnamese, Chinese, and Korean).
- Use of revised billing statements that provide the applicant a 30-day, 45 day, and 60 day notice when a payment has not been received. The notice includes information about making cash payments to Rite Aid stores to ensure timely payments.
- Authorization request included on the Add A Child Forms, Annual Eligibility Forms and applications to permit the program to forward applicant information to Medi-Cal. Authorization requests are also included in notification letters to applicants who did not meet the income eligibility criteria for Healthy Families and who may qualify for Medi-Cal, and who did not initially authorize the program to forward their information to Medi-Cal.

E. Benefit structure

F. Cost-sharing

The dollar value of premiums do not appear to present an enrollment barrier to families in the program. However, timely and regular payment of premiums does appear to be problematic for some families. To date, disenrollment for non-payment of premiums accounts for 36% of all disenrollments. MRMIB attempts to survey all subscribers disenrolled due to non-payment of premiums. Of 33% of subscribers responding to the survey (July 2000 – August 2001) 11.9% stated they could not afford premiums.

Additionally, between April 2001 and August 2001 MRMIB attempted to call subscribers who were to be disenrolled due to non-payment of premiums. During these five months 24% were contacted and it was found that only 3% indicated they could not afford premiums.

G. Delivery system

The HFP has employed successful approaches to improving delivery of health, dental and vision services:

- As an incentive to include traditional and safety net providers in their network, health plans with the highest percentage of traditional and safety net providers in their network are designated as a Community Provider Plan (CPP). Plans with the Community Provider Plan designation are offered at a $3 discount per child per monthly premium discount. Traditional and safety net providers are available in all areas of the state, and all HFP subscribers have access. Currently 16 of 27 participating health plans are designated as a Community Provider Plan (CPP) in at least one county. Of all HFP subscribers, 36% are enrolled in a CPP and receive a $3 per month premium discount.
- Providing coverage in the rural areas continues to present a challenge. To meet the challenge, California implemented a Rural Health Demonstration Project. This project provides contract enhancements to health, dental, and vision plans participating in the program to expand access of services to rural areas. The Rural Health Demonstration Project has been a successful vehicle for developing partnerships between rural providers and private health and dental plans. These partnerships and the augmented funding have improved access in rural areas and to special populations. Each project that was awarded was reviewed.
- The HFP Internet website (www.mrmib.ca.gov), using a network information service, provides network information including physicians, language, gender and specialty This service promotes choice for families.

H. Coordination with other programs

Areas of coordination between the Healthy Families Program and other programs that have been successful include:

- The joint application and identical eligibility standards for HFP and MCC make it easier for families and CAAs to complete applications.
- Building on existing programs such as CCS guarantees continuity of care with plans participating in both programs (via MOU), families with children in both can have a single network.
- Development of a common set of responsibilities via MOUs provided the foundation for establishing necessary relationships between the plans and CCS/County Mental Health organizations.
- Early coordination of services between the state programs, regular meetings with plans, local program staff and designated liaisons for each involved entity proved valuable.
- Families who are ineligible due to higher income are referred to a philanthropic insurance program offered by Kaiser Foundation Health Plan and CaliforniaKids.

I. Crowd-out

Crowd-out under the HFP/MCC has not been identified in any significant degree.

J. Other

Based on the first CAHPS® 2.0 survey, it appears that HFP subscribers are very pleased with the program. Results from the survey indicate:

- 86.2% of respondents gave a positive response when asked how well their doctors communicate;
- 83.5% of respondents stated they were able to get the care they felt was necessary;
- 84.9% of respondents indicated they experienced no problem or delay in their child's care while awaiting approval;
- 89.7% of respondents replied that their doctor usually or always listened carefully;
- 87.0% of respondents reported that their doctor usually or always explained things in an understandable manner;
- 91.5% of respondents felt their doctor usually or always showed respect;
- 89.3% of respondents stated that office staff usually or always treated them with respect;
- 89.1% of respondents noted experiencing 14 days or less between making an appointment for routine care and the child seeing a provider;
- 85.8% of respondents reported that their child's doctor usually or always involved them in decisions; and
- 82.6% of respondents indicated not having a problem getting doctors to follow up on concerns.

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2001, your current fiscal year budget, and FFY 2003-projected budget. Please describe in narrative any details of your planned use of funds.

N*ote: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).*

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs 1)			
Insurance payments			
Managed care	$406,378,073	$527,455,171	$621,703,346
per member/per month rate X # of eligibles			
Fee for Service	$45,356,927	$91,996,050	$126,126,025
Total Benefit Costs	$451,735,000	$619,451,221	$747,829,371
(Offsetting beneficiary cost sharing payments)	-$29,375,230	-$35,417,266	-$39,534,537
Net Benefit Costs	$422,359,770	$584,033,955	$708,294,834
Administration Costs 1)			
Personnel			
General administration	$29,208,951	$49,664,324	$53,922,988
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/marketing costs 2)	$21,194,797	$20,295,250	$13,806,694
Other			
Total Administration Costs 3)	$50,403,748	$69,959,574	$67,729,682
10% Administrative Cost Ceiling	$46,928,863	$64,892,662	$78,699,426
Federal Share (multiplied by enhanced FMAP rate)	$311,456,793	$421,802,301	$504,415,935
State Share 4)	$161,306,725	$232,191,228	$271,608,581
TOTAL PROGRAM COSTS 1)	$472,763,518	$653,993,529	$776,024,516

1) Budgeted costs do not include impact of pending SCHIP waiver to expand services to parents.
2) For FFY 2001, includes only expenditures from 10% outreach allowance for FFY 98 retained allotment which are exempt from the administrative cap.
3) For FFY 2001, administrative costs subject to the 10% cap would include only the $29,208,951 reported under General Administration.
4) For FFY 2002, includes $5,066,912 in administration costs over the Cost Ceiling (10% cap).

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__X__State appropriations
__X__County/local funds
_____Employer contributions
__X__Foundation grants
_____Private donations (such as United Way, sponsorship)
_____Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

No, however the Foundation grants are normally only awarded for one-year periods.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name	Medi-Cal for Children	Healthy Families Program
Provides presumptive eligibility for children	_X_ No _____ Yes, for whom and how long?	_X_ No _____ Yes, for whom and how long?
Provides retroactive eligibility	_____ No _X_ Yes, for whom and how long? Up to 90 days.	_X_ No _____ Yes, for whom and how long?
Makes eligibility determination	_____ State Medicaid eligibility staff _____ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _X_ Other *(specify)* _County	_____ State Medicaid eligibility staff _X_ Contractor _____ Community-based organizations _____ Insurance agents _____ MCO staff _____ Other *(specify)*
Average length of stay on program	Specify months _12 months	Specify months _12 months
Has joint application for Medicaid and SCHIP	_____ No _X_ Yes	_____ No _X_ Yes
Has a mail-in application	_____ No _X_ Yes	_____ No _X_ Yes
Can apply for program over phone	_X_ No _____ Yes	_X_ No _____ Yes
Can apply for program over internet	_X_ No _____ Yes	_____ No _X_ Yes, Pilot program in San Diego county only
Requires face-to-face interview during initial application	_X_ No _____ Yes	_X_ No _____ Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_X_ No _____ Yes, specify number of months What exemptions do you provide?	_____ No _X_ Yes, specify number of months _3 What exemptions do you provide? • Applicant lost or changed jobs • Family moved to area not covered • Employer discontinued benefits to all employees • COBRA coverage ended • Child reached benefit maximum in current health

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
		plan
Provides period of continuous coverage regardless of income changes	_____No __X__ Yes, specify number of months ___12 __ Explain circumstances when a child would lose eligibility during the time period Child turns 19, by request, death, incarceration, moves out of state.	_____No __X__Yes, specify number of months ___12 Explain circumstances when a child would lose eligibility during the time period: *Becomes 19 years old; by request; non-payment of premiums.*
Imposes premiums or enrollment fees	__x__No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	_____No __x__Yes, how much? *$4.00 to $9.00 per child with a maximum of $27.00 per month for all children in the family*. Who Can Pay? __X__ Employer (*with specified exceptions*) __X__ Family __X__ Absent parent __X__ Private donations/sponsorship ____ Other (specify)
Imposes copayments or coinsurance	__X__No _____Yes	_____No __X__Yes
Provides preprinted redetermination process	__X__ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No __X__ Yes, we send out form to family with their information and: __X__ask for a signed confirmation that information is still correct ____do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

The HFP process is simpler. Personalized forms are sent to families and only current income documentation is needed.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

0-200% of FPL for children under age 1
0-133% of FPL for children aged 1-6
0-100% of FPL for children aged 7-13

Medicaid SCHIP Expansion

0-100% of FPL for children aged 14-18

Separate SCHIP Program

200-250% of FPL for children aged 0-1
134-250% of FPL for children aged 1-6
100-250% of FPL for children aged 7-18

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? ***Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".***

Monthly maximum deductible amounts for each child and disabled dependent are:

Child under the age of 2	$200
Child age 2 or older	$175
Disabled dependent of any age	$175

Work Expense Deductions:

Up to a $90 deduction is given for each person in a family working or receiving State Disability Insurance or Workers Compensation.

Child Support and Alimony Deductions:

If the applicant receives income from child support or alimony, a $50 deduction from the family income is made.

Do rules differ for applicants and recipients (or between initial enrollment and redetermination)

____ Yes __X__ No

If yes, please report rules for applicants (initial enrollment).

For table 6.2 see response to question 6.2.

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	Separate SCHIP Program
Earnings	$	$	$
Self-employment expenses	$	$	$
Alimony payments Received	$	$	$
Paid	$	$	$
Child support payments Received	$	$	$
Paid	$	$	$
Child care expenses	$	$	$
Medical care expenses	$	$	$
Gifts	$	$	$
Other types of disregards/deductions (specify)	$	$	$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

__X__No ___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

__X__No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

__X__No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

_____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?

____Yes __X__No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

A. Family coverage

On December 19, 2000 California submitted a request for a waiver to extend coverage to uninsured parents. Coverage would be extended to parents of enrolled children in families with incomes between 100 and 200 % of fpl and parents with incomes below 100% who do not qualify for Medicaid. Legislation necessary to implement the expansion has been enacted. The State's waiver request remains under review by the Federal government.

B. Employer sponsored insurance buy-in

C. 1115 waiver

See answer to question #A

D. Eligibility including presumptive and continuous eligibility

E. Outreach

NC.

F. Enrollment/redetermination process

NC.

G. Contracting

NC.

H. Other

NA.

Appendix

Eligibility Determination Process
The eligibility determination process starts with a simple four-page document, which provides initial participant data. To document income eligibility, applicants provide pay stubs, a signed letter from employer verifying income, federal tax return or current profit and loss statement with the application. A completed application takes 10 days to determine eligibility, which includes a Single Point of Entry screening for no-cost Medi-Cal of four days. If the applicant is Healthy Families eligible, an additional 10 days is required by the health plan to process, enroll, and provide the subscriber with the required ID cards and enrollment packets. The Program Administrative Vendor uses "Eligibility Enrollment Specialists" to review and approve the initial eligibility and application. Approval is provided when all eligibility requirements are satisfied. A welcome letter is sent after approval and a “welcome call” is made 10 to 20 days from the effective date of enrollment.

Eligibility/Redetermination Process
Continuous eligibility for the Healthy Families Program (HFP) is for 12 months. Each year an annual eligibility review (AER) is done to confirm a member's continuing qualification for the HFP. AER is a two-page customized package requesting the applicant to review and update family composition changes and provide income. Just like the initial application process, income documentation must accompany the AER package. If the applicant responds in a timely manner, there is no break in coverage. Adding a child will change the family’s anniversary date to the date the last child was enrolled. The program administrative vendor utilizes a separate group of eligibility specialists to review and approve AER packets.

Coordination

Medi-Cal
California recognizes that coordination between HFP and Medi-Cal is an important factor in ensuring that low-income families have access to continuous health care coverage. Both programs rely on income, family size and income deductions to determine a child's eligibility.

A *joint application* form for the Healthy Families Program and Medi-Cal has been successfully implemented.

A "*single point of entry*" receives and screens all mail-in applications.

When children served by Medi-Cal experience increased family incomes, which would cause them to no longer be eligible for no cost Medi-Cal coverage, they are granted an additional one month of eligibility.

Implementing a resource disregard for children in the Medi-Cal federal poverty level programs and utilization of income deductions in the Healthy Families Program further facilitates coordination between Medi-Cal and the Healthy Families Program. California also closely coordinates with programs offering specialized services provided by the California Children's Services Program and the County Mental Health Program.

Child Health Disability Program
Children come to Healthy Families through a "*gateway program*" called CHDP. CHDP providers offer early medical screens and immunizations (following EPSDT guidelines) for children under 200% of FPL and perform a critical eligibility screening and referral function to HFP. When children receive services from a CHDP provider, they are either referred to Medi-Cal or to the Healthy Families Program. Should follow-up treatments be required for a condition identified in the CHDP screen, Medi-Cal or the Healthy Families Program (depending on which program the child ultimately enrolls in) will cover the cost of care provided to children for 90 days prior to enrollment.

California Children's Services
The CCS program has been integrated into the HFP benefit design, CCS provides case management and treatment for chronic, serious, and complex physically handicapping conditions. Children receiving such services continue to have their primary health needs served through the Healthy Families Program's health, dental and vision plans. Data reported by participating plans showed that 4,994 referrals to CCS were made during SFY 2000/01.

County Mental Health Departments
Children with serious emotional disturbances (estimated at between three to five percent of the general population) are referred by the HFP participating health plans to the county mental health program for treatment. The referral is made, pursuant to a Memorandum of Understanding (MOU) between the two organizations, for treatment of serious emotional disturbances. Data reporting by participating health plans showed that 1,098 referrals to county mental health departments were made referrals during SFY 2000/01.

The required MOU formalizes this important arrangement. The county mental health program coordinates the delivery of mental health and other health services with the health plan for those children who meet the criteria of serious emotional disturbance. County mental health programs provide mental health treatment services directly or through contracts with private organizations and individual providers.

Rural Health

For the rural areas, California has initiated a Rural Health Demonstration Project. This project is designed to increase the number of providers or enhance the access to providers in rural areas of the state. As of July 2001, the RHDP has funded 132 different projects. Since July 1998, $18 million has been encumbered; $9 million for projects that enhance access to care for children with migrant and seasonal worker parents and $9 million for projects that increase the number of providers in a geographic area. This funding has been allocated to projects throughout California concentrating on clinics in rural counties that are geographically isolated, or counties with high concentrations of special populations that may be linguistically isolated or otherwise not afforded access to health, dental or vision insurance.

In addition to the RHDP, MRMIB has made available a *Rural Health Plan combination* designated as a statewide plan choice providing access to migrant and seasonal farm workers, native Americans, and children of families working in the fishing and forestry industry. The plan is a combination of health, dental and vision insurance. Healthy Families subscribers who identify themselves as one of the above groups can enroll in this program and receive access to services anywhere in the state, regardless of their county of residence, as long as they remain California residents.

Projects throughout the State range in complexity; from increasing the normal business hours to provide services in the evenings and weekends to Telemedicine projects and mobile dental clinics.

The types of projects funded through MRMIB differ from county to county depending on local needs. The goal is to fund projects that satisfy the needs and best serve the interests of the HFP participants.